February 1, 2001

I am pleased to announce the availability of up to $40 million as one-year grants to communities to further their development of integrated delivery systems for the uninsured and underinsured. This amount of funding is part of $125 million that was appropriated for the Community Access Program (CAP) under the fiscal year 2001 HHS Appropriations Act. Grants will vary in size, based on the scope of the project and the size of the service area. Approximately 40 awards are anticipated, with an average grant award of $1 million. It is our intent to fund those applicants that either serve a target population that is distinct from the target population of other applicants or current CAP grantees, or propose distinct strategies that are coordinated and complimentary to those applicants or CAP grantees that have overlapping populations.

Attached is a complete application kit, which includes the CAP Program and Application Guidance and Standard Form PHS 5161-1 (Rev. 7/00). The purpose of the CAP Program Application Guidance is to describe the program priorities, instructions for applying, and review criteria for making funding decisions. Applicants are advised to carefully review the "Eligible Applicants" section on page 6 of the CAP Program Application Guidance before making a decision to apply for funds. [Note: Current CAP grantees are not eligible to apply for this funding. A separate application guidance for supplemental/expansion grants to current grantees will be available at a later date.] The "Application Format and Instructions" section on pages 9-16 describes the requirements for the narrative portion of the application, which should be no more than 42 pages. The "Application Review Criteria" on pages 17-19 describe the factors that an objective review committee will be looking for in assessing and ranking eligible applications.

Applications are due on May 7, 2001. The "Application Submission and Review Process" section on pages 20-22 describes how the components of the application should be assembled and where to submit a completed application. Prior to submitting a completed application, applicants are advised to log on to the CAP Web site (www.hrsa.gov/cap) to learn of any updates or further instructions for funding.

If you have any questions regarding this funding opportunity, please contact the CAP staff at 301-443-0536 or any of the Field Office staff listed on page 22 of the CAP Program and Application Guidance.

Best Wishes,

Eric T. Baumgartner, M.D., M.P.H.
Director
Community Access and State Planning Programs

Attachments:
Table of Contents
CAP Program Application Guidance
Standard Form PHS 5161-1 (Rev. 7/00)

APPLICATION KIT
TABLE OF CONTENTS

CAP Program Application Guidance
CFDA# 93.252

U.S. Department of Health and Human Services
Public Health Service Grant Application
Form PHS 5161-1 (Rev. 7/00)

COMMUNITY ACCESS PROGRAM
PROGRAM APPLICATION GUIDANCE
CFDA #93.252

BACKGROUND

In 1999, 42.6 million people in the United States did not have health insurance. Of these, 24.2 million were employed -- 19 million worked full time and 5.2 million worked part time.

The uninsured and underinsured often have complex medical needs, remain outside organized systems of care, and have insufficient resources to obtain care. They may defer care or not receive needed services, and they are about half as likely to receive a routine check-up as insured adults. The uninsured and underinsured also rely heavily on expensive emergency rooms, and because they lack a routine source of care, they often do not receive needed follow-up services.

Many of the uninsured and underinsured rely on the nation's institutions, systems, and individual health professionals that provide a significant volume of health care services without regard for ability to pay. In many communities, these providers are struggling to care for the increasing numbers of uninsured and underinsured individuals. They face many challenges such as an uneven distribution of the burden of uncompensated care, the fragmentation of services for the uninsured, insufficient numbers of certain types of providers, reduced Medicaid revenues due to the pressures of Medicaid managed care, and a growing need for mental health and substance abuse services.

While integration among these providers is critical to serve the uninsured and underinsured with greater efficiency and to improve quality of care, many of these providers are so pressured by basic caregiving tasks, they need assistance to coordinate their efforts with other providers and to develop integrated community-based systems of care.

The Department of Health and Human Services (DHHS) is committed to assisting communities and their safety net providers in developing integrated health care delivery systems that serve the uninsured and underinsured with greater efficiency and improved quality care. In FY 2000, DHHS provided about $23 million in funding for 23 communities for infrastructure development. In FY 2001, up to $40 million will be available as one year grants for additional communities to further their development of integrated delivery systems for the uninsured and underinsured.

This announcement provides information and application guidance on this DHHS initiative – the Community Access Program (CAP). Up to $40 million in available funding is part of $125 million, which has been appropriated for CAP under the FY 2001 HHS Appropriations Act. The initiative will be managed by the Health Resources and Services Administration. Grants will vary in size, based on the scope of the project and

the size of the service area. With an average grant award of $1 million, approximately 40 awards are anticipated. We welcome applications from smaller communities, rural communities, and tribal organizations.

This HRSA program will support infrastructure development in communities that have already begun to reorganize and integrate their health care delivery systems. FY 2001 funding is not intended to support those communities that have not yet begun the planning and development of necessary organizational structure.

This program shares some of the same goals of the W.K. Kellogg Foundation's Community Voices Program and the Robert Wood Johnson Foundation's Communities in Charge Program. Thus, CAP will take into account the experiences of these foundations as well as other programs that promote the integration of services to the uninsured and underinsured.

THE COMMUNITY ACCESS PROGRAM

Program Purpose: The purpose of this program is to assist communities and consortia of health care providers to develop the infrastructure necessary to fully develop or strengthen integrated health systems of care that coordinate health services for the uninsured and underinsured.

Program Goal: The coordination of services through the CAP grant will allow the uninsured and underinsured to receive more efficient and higher quality care and gain entry into a comprehensive system of care. The system will be characterized by effective collaboration, information sharing, and clinical and financial coordination among all levels of care in the community network. The system will be committed to continuous performance improvement, implementation of best practices, staff development, and real-time feedback of outcomes of care. Care management (e.g., case, disease) will be applied across the continuum for those with chronic illnesses, high-risk individuals, and high utilizers. The system will also strive to provide universal access to the target population, and to improve the health status of the community population.

This vision requires a re-thinking of the relationships, priorities, and desired outcomes for local or regional care delivery. It means adopting the philosophy that care for the ill and injured occurs within the context of a comprehensive system design of population health improvement.

The community being served should be actively involved in the system design. Broad understanding, two-way learning between providers and community, and participation in priority setting and governance by the community are essential components of this vision. This will assure sustainability of the system.

PROGRAM DESCRIPTION

We are seeking to fund a variety of program models in communities that have an established track record for building partnerships and that have completed the basic planning necessary to implement a coordinated system of care. The successful applicant will design a project that builds upon its current capacities and strengths; brings the major players in the political and health delivery systems to the table; uses the federal funds available to plan a transition to an expanded and innovative approach that will ultimately be competitive within its own market; and will sustain the delivery of services and funding after these federal grants expire. The successful applicant will work with its county board, city council, state legislature, and state health programs to assure the coordination and efficient use of all available resources to achieve program goals.

There is no one successful model that we are trying to replicate. Rather, there are many models that already exist and that each community may draw from in creating a project to address its own needs.

In surveying innovative community approaches to the provision of safety net services, we have come across communities that have:

- coordinated the provision of care through public hospitals, public health departments, and community health centers;
- linked hospital and clinic services through state of the art data systems which allow transitions between Medicaid, uninsured, and insured status for low income populations;
- combined the development of managed care networks for the indigent funded through local tax increases and the redirection of funds towards the care network and away from the support of tertiary care at public hospitals;
- created networks to allocate uncompensated ambulatory care loads among physicians and redistribute caseloads to private providers; and
- linked behavioral and acute care services.

We are looking for applicants with clear goals, an operational plan for meeting those goals, a history of commitment to serving indigent populations, and enough of a track record to indicate a reasonable chance at being successful. Innovative proposals for sustaining the service delivery component of projects could include use of local or state taxing authorities, use of tobacco settlement funds, and creative partnerships with the provider and business communities. Applications will be judged from the perspective of whether the financing proposed is realistic–given state and community resources–and appropriate to the project proposed. It is our intent to fund those applicants that either serve a target population that is distinct from the target population of other applicants or current CAP grantees, or propose distinct strategies that are coordinated and complimentary to those applicants or CAP grantees that have overlapping target populations.

Funded projects will address several common elements:

Community Need: Funded communities will have high or increasing rates of uninsured and underinsured and will have identified specific organizational needs within existing delivery systems. A "community" for the purpose of this program may be based on geography or a population group (e.g., the homeless) as defined by the people in the community.

Collaboration Among Safety Net Providers: Funded communities will build upon current investments in communities for serving these populations and include the safety net providers who have traditionally provided services without regard to the ability to pay. The coalition should be built upon formal arrangements among the partners that define the extent of the commitment and involvement in policy development and decision-making from each partner.

Comprehensive Services: Funded communities will include all partners necessary to assure access to a full range of services, including mental health and substance abuse treatment. It is anticipated that the health services (prevention, primary, and specialty) provided by Federally-supported programs that are present in the community will be part of this coalition of providers.

Coordination with Public Insurance Programs: Funded communities will demonstrate coordination (e.g., memoranda of agreements) with state programs to ensure that eligible beneficiaries are enrolled in public insurance programs (e.g., SCHIP, Medicaid).

Community Involvement: Funded communities will have strong community support for these efforts, which provide a broad foundation of assistance to the provider community undertaking this project. Management and governance structures should be in place that assure accountability to funders and define the community role in setting policy. The community involvement in the development, implementation, and governance of the project should be evident. This should include the leadership within the appropriate legislative and executive bodies, providers identified above, health plans and payers, community leaders and consumers.

Sustainability: Funded communities will have a plan for long-term sustainability. There should be evidence that the program is capable of leveraging other sources of funds and integrating current funding sources in a way to assure long-term sustainability of the project.

ELIGIBLE APPLICANTS

To encourage the development of different models, this program seeks a variety of applicants representing all types of communities. Applicants that receive funding may be large health care systems or small organizations. Applications are encouraged from large urban areas, small rural communities, and tribal organizations.

Applications may be submitted by public and private non-profit entities that demonstrate a commitment to and experience with providing a continuum of care to uninsured individuals. Each applicant must represent a community-wide coalition that is committed to the project and includes safety net providers (where they exist) who have traditionally provided care to the community's uninsured and underinsured regardless of ability to pay. **The community-wide coalition must consist of partners from all levels of care (i.e., primary, secondary, tertiary) and partners who represent a range of services (e.g., mental health and substance abuse treatment, maternal and child health care, oral health, HIV/AIDS care).**

Examples of eligible applicants which may apply on behalf of the community-wide coalition include but are not limited to:

- A consortium or network of providers (e.g., public and charitable hospitals; community, migrant, homeless, public housing, and school-based health centers; rural health clinics; free health clinics; teaching hospitals and academic institutions)
- Local government agencies (e.g., local public health departments with service delivery components)
- Tribal governments
- Managed care plans or other payers (e.g., HMOs)
- Agencies of State government, multi-state health systems, or other groups may submit applications on behalf of multiple communities if they demonstrate the ability to coordinate community health care delivery systems and bring resources to the community.

Existing CAP grantees are not eligible to apply for this funding.

FUNDING CRITERIA

Review criteria that will be used to evaluate applications include:

- Evidence that the target population has a high or increasing rate of uninsurance
- Evidence of progress towards integration prior to application for funding
- Appropriateness and quality of clinical services to be provided
- Accountable management and budget plan with supporting data systems
- Evidence of established partnerships among a broad-based community consortium
- Commitments from local government agencies, public and private health care providers, community leaders
- Demonstration of existing and sustainable public and private funding sources
- Commitment to self evaluation and participation in a national evaluation

PROGRAM EXPECTATIONS

Funding through this initiative may be used to support a variety of projects that would improve access to all levels of care for the uninsured and underinsured through coordinated systems of care. Each community should design a project that best addresses the needs of the uninsured and underinsured and the providers in their community.

Examples of activities that could be supported with this funding include:

- Offering a comprehensive delivery system for the uninsured and underinsured through a network of safety net providers. [Single registration, eligibility systems]

- Integrating preventive, mental health, substance abuse, HIV/AIDS, and maternal and child health services within the system. [Block grant funded services, other DHHS programs, state and local programs]

- Developing a shared information system among the community's safety net providers. [Tracking, case management, medical records, financial records]

- Developing and incorporating shared clinical protocols, quality improvement systems, utilization management systems, and error prevention systems.

- Sharing core management functions. [Finance, purchasing, appointment systems]

- Coordinating and strengthening priority services to specific targeted patient groups.

- Developing affordable pharmaceutical services.

Applicants will be expected to budget for travel to two grantee meetings, and to meet interim and final reporting requirements as directed by the CAP Office.

USE OF GRANT FUNDS

Funding provided through this program may NOT be used to substitute for or duplicate funds currently supporting similar activities. Grant funds may support costs such as:

- Project staff salaries
- Consultant support
- Management information systems (e.g., hardware and software)
- Project-related travel
- Other direct expenses necessary for the integration of administrative, clinical, information system, or financial functions
- Program evaluation activities

With appropriate justification on why funds are needed to support the following costs, **up to a total of 15 percent of grant funds** may be used for any combination of the following:

- Alteration or renovation of facilities
- Primary care site development
- Service expansions or direct patient care

Grant funds may NOT be used for:

- Construction
- Reserve requirements for state insurance licensure

EXPECTED RESULTS

The integration and coordination of services among a community's safety net providers are expected to result in:

- A system of care that provides coordinated care to the target population.

- Increased access to primary care resulting in a reduction in hospital admissions for ambulatory sensitive conditions among the uninsured.

- Elimination of unnecessary, duplicate functions in service delivery and administrative functions, resulting in savings to reinvest in the system.

- Increased numbers of low-income uninsured people with access to a full range of health services.

APPLICATION FORMAT AND INSTRUCTIONS

The narrative portion of each application for the Community Access Program must be **no more than 42 pages** and must include the following sections in order to be considered eligible:

1. Cover Letter: A one-page cover letter should identify the community for which the application is being submitted, the lead organization with complete contact information, and the amount of grant funding being requested.

2. Table of Contents: A one-page table of contents should outline each section of the application and all appendices. (Not counted against the 42 page limit).

3. Community Profile: Applicants are required to fill out a brief profile of the community and the collaborative (see Appendix A).

4. Project Abstract *(2 page limit):* A project abstract should briefly describe each of the following:

   - Applicant community
   - Target population
   - Current delivery system for the uninsured and underinsured
   - Goal of the proposed project
   - Activities that the grant would support
   - Partners collaborating on the project
   - Projected results

5. Community Needs Assessment *(3 page limit suggested)*: This section should describe the current needs of the community. The community needs assessment should identify the service area for the project, describe the target population, and assess the current delivery system for the target population. The needs assessment should serve as the basis for the project plan and should specifically include the following:

   - Description of the current delivery system – Include an assessment of existing resources and programs for the uninsured and underinsured, the types of providers who deliver the most care for this population, barriers in the current delivery system, and gaps in service delivery. If available, provide information on the number or proportion of uninsured or underinsured in each provider's caseload and/or the share of the total community-wide uninsured care that it provides.

- ✍ Target population – Include data that describe the number of uninsured and underinsured, and project the number of these individuals that expect to be impacted by your proposed project. To the extent possible, also describe the income status and cultural diversity of this population. The most current data available should be cited. Also, include an analysis of why the target population is uninsured or underinsured. If the target population for the project is a subset of the community's uninsured and underinsured population, explain why this subpopulation is being given priority.

  [If available, a legible map that denotes the location of the service area and targeted population should be included as Appendix 1.]

- ✍ Projection of potential changes in insurance coverage – Include a discussion of any projected increases or declines in private or public insurance coverage. Describe any community efforts designed to expand coverage.

- ✍ Assessment of most urgent needs – Include an assessment of the most urgent needs of the project's target population (e.g., emergency care, pharmacy, coordination of care, access to specialty services, immunizations, dental services).

6. Evidence of Progress Towards Developing an Integrated System of Care for the Target Population *(4 page limit suggested):* This section should describe the accomplishments made to date by the collaborators towards the development and implementation of an integrated health system to serve the target population. Specifically, the application should describe each of the following:

   - ✍ Evidence of community-wide collaboration – Provide evidence that the collaborators are proposing to serve a target population that is distinct from the target population of other applicants or current CAP grantees, or provide evidence that the collaborators' strategies are coordinated and complimentary to those applicants or CAP grantees that have overlapping target populations.

   - ✍ History and progress of collaboration – List the active partners who are part of the integrated system and describe any system integration efforts that have already taken place.

   - ✍ Formal arrangements already established within the community – Describe any formal relationships or structures that bind the collaborators.

     [Memoranda of agreement, state or local founding arrangements, tribal resolutions, or other official documents should be included as Appendix 2]

   - ✍ Capacity to assume grant – Include a brief history of the lead organization's experience in leading and managing the partnership. Also, describe the lead

organization's capacity for assuming direct fiduciary responsibility over the administration and management of the project.

7. Statement of Project and Budget *(12 page limit suggested)*: Based on the community needs assessment, this section should describe the proposed project. Specifically, the application should describe each of the following:

   ✍ Statement of project – In narrative format, describe the specific program objectives and the action steps planned to achieve each objective. Also, describe how the program objectives relate to the community needs assessment. Describe what will change in the community as a result of the grant.

   ✍ Project management matrix – Include a matrix that lists the objectives, action steps to accomplish each objective, when and by whom results are expected to be achieved, and how they will be measured. The matrix should be organized as follows:

   (NOTE: Applicants may have as many objectives and actions steps needed for their proposed project and are not limited to 2 objectives with 3 action steps each.)

Objective 1:			
	Timetable for Each Action Step	Responsible Organization or Person	Anticipated Results
Action Step 1:			
Action Step 2:			
Action Step 3:			
Objective 2:			
	Timetable for Each Action Step	Responsible Organization or Person	Anticipated Results
Action Step 1:			
Action Step 2:			
Action Step 3:			

Management Information Systems – If one of the project's components includes the development of a management information system (MIS), please append a supplemental description of the existing MIS and the proposed enhancements.

[*If applicable, this section should be included as Appendix 3 and should not be more than 3 pages]*

This supplemental information on MIS development will be reviewed separately by a technical review panel. The supplemental descriptions should also include the following:

- The goals of the MIS project and how they fit into the overall goals and needs of the program.

- The current and intended system, including plans to manage data and create or purchase software; connectivity such as wide area networks, web-based access, smart cards and expanded connections to existing mainframe systems; compliance with HIPAA requirements for patient privacy and confidentiality, and security plans.

- The implementation steps, the current status of implementation, and planned training for users of the system.

- The decision-making process for MIS including how the proposed activities were selected, who was consulted, and how ongoing decisions related to data elements and definitions will be reached.

- What is expected to be funded under the grant (e.g., hardware, software, personnel, consultants)?

- How system maintenance and upgrades will be sustained after the grant.

✍ Organizational structure and accountability – Describe the management, accounting, and governance structure of the collaboration. Describe how the governance structure is reflective of all partners and how it assures on-going accountability to the entire community collaboration. Include any plans for a formal affiliation or describe existing affiliation agreements.

[Provide resumes and/or position descriptions for key staff and an organizational chart as Appendix 4].

✍ Budget plan – The budget plan for the project must provide the following:

- An itemized budget that is coordinated with the project management plan. The budget should account for the total grant funds requested and should separately include any other funds that would be used for the project. In

addition to the itemized budget, provide a brief narrative for each line item on the budget. **The budget is for one year only.**

- Description of how grant funds would be managed by the collaboration partners, including mechanisms for grant fund accountability.

- Explanation of why the project cannot be implemented with the coalition's existing resources.

- Assurance that grant funds will not be used to supplant other funding that is currently supporting services to the target population.

- **Applicants must include funds in the budget for three-four persons to attend each of two grantee meetings over the course of the grant year.**

- Previously negotiated Federal indirect cost rates will be accepted. These costs must be included in the budget.

8. Scope and Quality of Services *(7 page limit suggested)*: This section should describe the scope of the services proposed in this project and the quality of services that would be provided to the target population. Specifically, the application should describe each of the following:

   ✍ Collaboration among a range of providers in the community – Demonstrate that the collaboration involves all appropriate health care providers, including mental health and substance abuse treatment providers, necessary to assure access to the range of services planned to be delivered to the target population. Provide criteria for the inclusion or exclusion of providers in the project's network.

   ✍ System coordination – Describe how the project's services will be coordinated. Also, describe the information and patient tracking systems that will be used and any plans for joint system development across providers. Discuss the impact of this coordination on the target population.

   ✍ Clinical quality – Describe the methods, objectives, and instruments for measuring and evaluating clinical quality.

   ✍ Cultural and linguistic competency – Describe how culturally and linguistically appropriate services will be ensured.

   ✍ Links to social services – Describe links with social services and enabling services in the community.

9. Community Partnerships and Sustainability *(5 page limit suggested):* This section should describe the community's vision for and plan to develop an integrated, sustainable delivery system. Specifically, the application should describe each of the following:

   ✍ Community involvement – Describe which elements of the community were involved in the design of the project and how they will continue to be involved in its implementation.

   [Letters of support from collaborators, other members of the community, or the state government should be attached as Appendix 5.]

   ✍ Commitment to the community and the population – Describe the historical commitment of the collaborators to the community's uninsured and underinsured. Provide evidence that the proposed project would build on current investments for serving the target population.

   ✍ Funding support and sustainability – Describe the current funding sources that support care for the uninsured and underinsured in the community; anticipated support of state and local governments, foundations and local philanthropy, or others; and plans for long-term sustainability of the project. Also, describe plans for continued financing of the activities of the collaboration beyond the one-year term of this grant.

   ✍ Reinvestment in the community – Describe how projected savings from project efficiencies would be used and how they would result in improved care for the target population.

10. Evaluation Plan *(7 page limit suggested):* This section should describe the applicant's plan for self evaluation and the capacity of the applicant to participate in a national program evaluation:

   ✍ Self evaluation plan – Describe the applicant's plan for self-evaluation and a monitoring process throughout the course of the grant that would be used to track and measure progress towards the project's goals and objectives as described in the logic model. Briefly specify the data needed and proposed collection methods. Also, briefly describe any applied health services evaluations that have already been conducted by the collaboration and are comparable to that described in the self-evaluation plan.

   ✍ National program evaluation – Indicate the applicant's commitment to participate in a national program evaluation and willingness to collect data required by the Secretary. Describe the capacity and limitations of the applicant's data system. At a minimum, applicants should be able to report on the number of uninsured and underinsured people in the community, the number of uninsured and

underinsured who receive care through the project, changes in these two measures over time, and changes in the volume of care (e.g., service increase). Interim and final program reports will be required as part of the national program evaluation.

✍ Logic model matrix – The logic model matrix will be the basis for the program's interim and final reports. A logic model describes the development of major project components in terms of resources required, activities, outputs, outcomes, and impact, and also describes the assumptions which have been made for each area as well as measures of success which will be applied. **The logic model matrix is for one year only. See sample matrix in Appendix B.**

- Resources are what you need in order to carry out program activities.
- Activities are what you do with those resources in order to achieve program goals.
- Outputs are what you expect those activities to produce.
- Outcomes are the short term and long term benefits or changes you expect to see happen as a result of the outputs.
- Impacts are the fundamental changes you are seeking long term.
- Assumptions are an explicit description of the reasoning behind each of the columns.
- Measures of success are the data collection elements and analysis which demonstrate each area.

The matrix should be organized as follows:

(NOTE: Applicants may have as many components as needed for their proposed project.)

Component 1:					
	Resources	**Activities**	**Outputs**	**Outcomes**	**Impact**
Definitions	What you need in order to carry out program activities:	What you do with those resources in order to achieve program goals:	What you expect those activities to produce:	What benefits or changes you expect to see happen as a result of the outputs:	What fundamental changes you are seeking in the long term:
Descriptions					
Assumptions					
Measures of Success					
Component 2:					
Descriptions					
Assumptions					
Measures of Success					

APPLICATION REVIEW CRITERIA

Each of the applications that has passed an eligibility and conformance review by the Federal staff will be assigned to members of an Objective Review Committee (ORC) for review. Members of the ORC will use the following evaluation criteria in their review of applications:

1. Community Needs Assessment (5 Points):

    1.1 Extent to which the applicant has provided evidence of significant unmet needs for the target population.

    1.2 Extent to which the target population has a high or increasing rate of uninsurance or underinsurance.

    1.3 Extent to which the income status and cultural diversity of the target population indicates high need.

    1.4 Extent to which the applicant documents projected declines in public or private insurance coverage.

2. Evidence of Progress towards Developing Integrated Systems for the Uninsured and Underinsured (15 Points):

    2.1 Evidence that the collaboration is proposing to serve a target population that is distinct from the target population of other applicants or current CAP grantees, or proposing distinct strategies that are coordinated and complimentary to those applicants or CAP grantees that have overlapping target populations.

    2.2 Evidence of collaboration partners' prior commitment to providing care to the target population.

    2.3 Evidence of results or accomplishments achieved from system integration efforts.

    2.4 Evidence of formal relationships among collaborators for project purposes.

    2.5 Capacity of the applicant to receive and administer funds on behalf of the coalition and evidence that it is authorized to act on behalf of the project partners.

3. Statement of Project and Budget (25 Points):

3.1 Extent to which the proposed project effectively addresses the needs of the target population as described in the needs assessment.

3.2 Extent to which the proposed project describes clear goals, objectives, planned activities, timeframes, and projected results that relate to and support the goals and objectives.

3.3 Extent to which the proposed project has an appropriate organizational structure and staff to carry out the plan.

3.4 Extent to which the itemized budget (with both existing funding sources and requested funding) is reasonable for the activities proposed and supports the project management plan.

3.5 Extent to which the proposed project describes who has authority for making financial decisions and how funds will be managed and accounted for.

3.6 Extent to which the MIS component furthers the goals of the overall project.

3.7 Extent to which the MIS component is technologically feasible.

4. Scope and Quality of Services (20 Points):

4.1 Extent to which the proposed project improves access to an appropriate range of services for the target population and adequate health care providers to carry out the project.

4.2 Extent to which the proposed project would coordinate services among project providers, manage patient referrals, and coordinate patient information.

4.3 Extent to which the proposed project would integrate substance abuse and mental health services into its system.

4.4 Extent to which the proposed project describes methods and objectives that would be used for measuring clinical quality.

4.5 Extent to which the proposed project describes methods and objectives that would be used for ensuring culturally and linguistically appropriate services.

4.6 Extent to which the proposed project describes appropriate linkages to social services and enabling services in the community.

5. Community Partnerships and Sustainability (20 Points):

   5.1 Extent to which the proposed project includes community participation in the design, management, and implementation of the project.

   5.2 Extent to which the proposed project includes a management structure to ensure ongoing community involvement.

   5.3 Extent to which the proposed project builds on current programs in the community that serve the uninsured and underinsured.

   5.4 Extent to which the proposed project involves those providers who have traditionally served the uninsured and underinsured in their community.

   5.5 Extent to which the ongoing governance structure involves the relevant participants in the community.

   5.6 Extent to which the proposed project demonstrates a firm commitment of State, local, and /or private funding and /or in-kind contributions dedicated to sustaining services for the target population.

6. Evaluation and Quality Improvement Plan (15 Points):

   6.1. Extent to which the proposed project has a self-evaluation plan that would track progress towards goals and objectives identified in the management plan and logic model.

   6.2 Extent to which the proposed project describes its information technology capability (e.g., capacity to report the number of uninsured people in the community, the number of uninsured who receive care, and changes in health status disparities over time) and any plans for enhancement.

   6.3 Extent to which the proposed project commits to participate in a national program evaluation.

   6.4 Extent to which the proposed project describes clear overall goals and objectives with resources, activities, outputs, assumptions, measures of success and projected outcomes and impacts that relate to and support the overall goals and objectives.

Up to 5 points may be deducted from the total score if the application does not conform to the requirements described on page 20 of this document.

APPLICATION SUBMISSION AND REVIEW PROCESS

Contact for Application Kit: To receive a complete application kit, contact the HRSA Grants Application Center at **1-877-HRSA-123**.

Pre-Application Workshops: There will be a series of six pre-application workshops conducted across the country. For more information on these workshops, call 301-443-0536.

Application Contents: Components of the application, all of which must be submitted, should be assembled in the following order:

- ✍ Standard Form PHS 5161-1 (Rev. 7/00) [Included with the Application Kit]
  - SF 424: Cover Page
  - SF 424 A: Budget Forms
  - SF 424 B: Assurances
  - Certifications, pp. 17-19
  - Checklist, pp. 25-26
  - Lobbying Disclosure (if applicable)
- ✍ Cover Letter
- ✍ Table of Contents
- ✍ Community Profile
- ✍ Application Sections as Outlined Above
- ✍ Appendices

The sections of the application must be presented in the order outlined above. The narrative section of the application **may not total more than 42 pages** (i.e, that portion of the application that is covered on pages 9-16 of this guidance). Allowable appendices are limited to those requested:

Appendix 1 – Map of the proposed service area
Appendix 2 – Memoranda of agreement or other evidence of collaboration
Appendix 3 – Description of MIS [if applicable]
Appendix 4 – Short resumes (no more than two pages each) and/or position descriptions of key staff and organizational chart
Appendix 5 – Letters of support

These appendices are not a substitute for the required elements of the narrative portion of the application and may not be included in the score. These appendices shall serve as evidence to substantiate what is included in the narrative portion of the application. Do not send additional information beyond these appendices.

Up to 5 points may be deducted from the total score if the application does not conform to these requirements.

Applications and appendices must:

- Be typed single-spaced in standard size black type (no smaller than Times New Roman 12) on 8 ½ x 11 paper that can be photocopied. Each page must be numbered consecutively;
- Have 1 inch border margins; and
- Only be typed on one side of each page.

State Point of Contact: This program has been determined to be subject to provisions of Executive Order 12372, as implemented by 45 CFR Part 100. Executive Order 12372 allows States the option of setting up a system for reviewing applications from within their States for assistance under certain Federal programs. The Form PHS 5161 contains a listing of States that have set up a review system and will provide a State point of contact (SPOC) in the State for the review.

Applicants (other than federally-recognized Indian tribal governments) should contact their SPOCs as early as possible to alert them to the prospective applications and receive any necessary instructions on the State process. For proposed projects serving more than one State, the applicant is advised to contact the SPOC of each affected State. The due date for State process recommendations is 60 days after the appropriate deadline dates. HRSA does not guarantee that it will accommodate or explain its responses to State process recommendations received after the due date. (See "intergovernmental Review of Federal Programs" Executive Order 12372, and 45 CFR Part 100, for a description of the review process and requirements.)

Address for Submission: Applicants must submit an original (with signature) and two copies of the application to:

Attn: CFDA #93.252
HRSA Grants Application Center
1815 N. Fort Myer Drive
Suite 300
Arlington, VA 22209

Applications to any other address will not be accepted.

Application Due Date: Applications are due on **May 7, 2001**. Applications will be considered as meeting the deadline if they are either (1) received on or before the deadline date or (2) postmarked on or before the deadline date and received in time for orderly processing. Applications that do not meet the deadline will be considered late and will be returned to the applicant.

Application Review Process: Applications will undergo an eligibility and conformance review by Federal staff. An Objective Review Committee will review applications that are deemed eligible. The HRSA will issue awards in **September 2001**.

Contact for Questions on the Application: Questions regarding this application guidance should be directed to the HRSA Field Office that serves your state:

NAME	TITLE	PHONE #	HRSA FIELD OFFICE	STATES AND US TERRITORIES COVERED
Ken Brown	Assistant Field Director	617-565-1420	Boston	Connecticut, Maine, Massachusetts, Rhode Island, Vermont, New Hampshire
Manley Khaleel	Chief, Primary Care	212-264-2549	New York	New York, New Jersey, Puerto Rico, Virgin Islands
Scott Otterbein	Associate Field Director for Primary Care	215-861-4414	Philadelphia	Pennsylvania, Delaware, Virginia, West Virginia, Maryland, District of Columbia
Stephen Dorage	Public Health Advisor	404-562-4127	Atlanta	Georgia, North Carolina, Alabama, Florida, Kentucky, Mississippi, South Carolina, Tennessee
Stephen A. Laslo	Regional Program Consultant	312-353-1658	Chicago	Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
Matthew Henk	Regional Program Consultant	816-426-5296 Ex. 239	Kansas City	Iowa, Kansas, Missouri, Nebraska
Jay McGath	Associate Field Director for Primary Care	214-767-4533	Dallas	Arkansas, Louisiana, New Mexico, Oklahoma, Texas
Nicholas Zucconi	Public Health Advisor	303-844-3203	Denver	Colorado, Montana, North Dakota, Utah, South Dakota, Wyoming
Irma Honda	Public Health Advisor	415-437-8078	San Francisco	Arizona, California, Hawaii, Nevada, Guam, America Samoa, Freely Associated States of the Pacific, and the Commonwealth Northern Mariana Islands
Beryl Cochran	Regional Program Consultant	206-615-2490	Seattle	Alaska, Idaho, Oregon, Washington

Timeline for Submission, Review, and Award:

February 12-16, 2001:	Pre-Application Workshops conducted in the following locations:

Nashville, TN	February 12, 2001
New Orleans, LA	February 12, 2001
Minneapolis, MN	February 14, 2001
Denver, CO	February 14, 2001
Philadelphia, PA	February 16, 2001
San Francisco, CA	February 16, 2001

May 7, 2001:	Applications due
June 11-22, 2001:	Applications reviewed by an Objective Review Committee
July/August 2001:	Validation site visits to selected applicants
September 2001:	Grant awards announced

CONTACT FOR ADDITIONAL INFORMATION

For further information regarding the Community Access Program, please visit our web site at www.hrsa.gov/cap or contact the program office:

Community Access Program Office
Health Resources and Services Administration
Parklawn Building, Suite 11-25
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-0536
Fax: (301) 443-0248

For further information regarding grant-related questions, please contact:

Office of Grants Management
Bureau of Primary Health Care
Health Resources and Services Administration
4350 East-West Highway, 11th Floor
Bethesda, MD 20814
Phone: (301) 594-4235
Fax: (301) 594-4073

APPENDIX A: COMMUNITY PROFILE

This information is requested to assist staff in analyzing the applications as a group. Information provided on this form will not affect the review or scoring of the applications. This form must be submitted in addition to the project abstract.

Applicant Name:

City and State:

Funding Requested: **Congressional District:**

Does the applicant currently receive other Federal grants? ✍ **Yes** ✍ **No**

Check whether the target area is urban, rural or tribal. (Check all that apply)

Type of Community	
Urban	
Rural	
Tribal	
Other	

If 'Other' is selected, specify:

_____

Check if the target area is near the US-Mexico Border, the Mississippi Delta, or is in an Urban Enterprise Zone/ Rural Enterprise Community. (Check all that apply)

Type of Area	
Border	
Delta	
EZ/EC	

What is the total population of the target community? _____

What percentage of the community is uninsured? _____

What sub-populations are targeted by this project? (Check all that apply)

Target Population	
All Uninsured	
Children	
Adults	
Elderly	
Workers	
HIV/AIDS	
Homeless	
Migrant	
Other	

If 'Other' is selected, specify:

_____

What ethnic groups are primarily targeted by this project? (Check all that apply)

If 'Other' is selected, specify:

_____

Target Population	
Caucasian	
African American	
Hispanic	
Asian/Pacific Islander	
Native American/Alaska Native	
Other	

What type of organization is the lead applicant?

If 'Other' is selected, specify:

_____

Type of Lead Organization	
Academic Medical Center	
Public Hospital	
Other Hospital	
AHEC	
University	
Community Health Center	
Other Community Based Provider	
Primary Care Association	
Provider Network	
Local Government/Health Dept	
Health Authority	
State Government	
Private Provider or Group Practice	
Medical or Dental Society	
Managed Care Plan	
Foundation	
Business	
Tribal Organization	
Other	

What types of organizations are the partner agencies? (Check all that apply)

If 'Other' is selected, specify:

_____

Type of Organization	
Academic Medical Center	
Public Hospital	
Other Hospital	
AHEC	
University	
Community Health Center	
MCH Program	
Ryan White/AIDS Provider	
Rural Provider	
Mental Health Program	
Substance Abuse Program	
Other Community Based Provider	
Community-Based Social Service Organization (Non-health)	
Primary Care Association	
Local Government/Health Dept	
State Government	
Private Provider or Group Practice	
Medical or Dental Society	
Managed Care Plan	
Foundation	
Business	
Tribal Organization	
Association or Advocacy Group	
Long-Term Care Provider	
School	
Veterans Administration	
Pharmacy	
Public Health Training Center	
Other	

What collaborative services will the grant funds support? (Check all that apply)

If 'Other' is selected, specify:

_____

Collaborative Services	
Management Information System	
Referral Network	
Enrollment/Patient Intake	
Transportation	
Case Management	
Other Enabling Service	
Coordinated Services	
Pharmacy	
Quality Management	
Electronic Medical Records	
Shared Clinical Protocols	
Sliding Fee Scales	
Other	

What health care services are to be provided by partner agencies? (Check all that apply)

If 'Other' is selected, specify:

_____

Targeted Services to be Provided	
Primary Care	
Mental Health-	
Substance Abuse	
Specialty Care	
Prevention	
Dental	
Pharmacy	
Social Service/Enabling	
Other	

What other resources support this project? (Check all that apply)

If 'Other' is selected, specify:

_____

Other Resources	
In-Kind Contributions	
State/Local Funds	
Private Funding	
Robert Wood Johnson Foundation's Communities in Charge	
WK Kellogg Foundation's Community Voices	
Other Foundation	
Tobacco Funds	
Program Income	
Other Federal Funding (please list) -- -- -- --	
Other	

History of Collaboration:

Collaboration Structure	Years
Formal- Incorporated	
Informal- Collaborative Agreements	
No Formal Agreement	

Appendix B: Sample Logic Model Matrix

Component 1: Development of a broad network of providers willing to provide services to uninsured/underinsured persons					
	Resources	**Activities**	**Outputs**	**Outcomes**	**Impact**
Definitions	What you need in order to carry out program activities:	What you do with those resources in order to achieve program goals:	What you expect those activities to produce:	What benefits or changes you expect to see happen as a result of the outputs:	What fundamental changes you are seeking in the long term:
Descriptions	Staff hired to execute the plan. In-kind assistance from community partners. Equipment and I/S support. Development of continued financial support.	Initiate volunteer recruitment campaign thorough meetings, mailings and on-on-one visits. Agreements executed with hospitals and specialty care physicians. Policies and procedures set for patient enrollment. Outreach plan to uninsured using volunteers and neighborhood centers.	A large pool of primary care physicians supplemented by full time MDs and NPs will provide a medical home for uninsured patients. Participating hospitals will provide the full array of hospital-based care.	By the end of year 1, 1000 clients will access a primary care provider.	All uninsured/underinsured individuals will have access to a primary care provider who will provide or arrange for the provision of mainstream medical care that is comparable to that available to the general public under existing insurance plans.
Assumptions	Sources for continued financial support	Staff will have sufficient resources and	Physicians will respond positively to recruitment	Health caregivers and public service agencies will	Those who receive care under the plan will

	will be identified.	support to develop all necessary contractual agreements and supporting documents. Issues regarding liability of volunteer health professionals can be satisfactorily resolved. Community support will increase through existing community partner volunteer groups. Physician champions can be recruited from the medical school and private sector who will effectively market the program to their colleagues. Retired physicians can be recruited and organized as primary care	efforts by physician champions and medical society staff. The primary hospital will be willing participants in the program. Uninsured people who generate unusually high hospital costs will be identified and enrolled.	identify uninsured persons and refer them for enrollment. Uninsured persons who currently do not receive care can be identified and enrolled through community groups. The program will be viewed positively by physicians, hospitals, government, public service agencies, churches and volunteer groups.	be managed at least the same level as the general insured public. The care management model will improve the quality of care to approach and overtake the generally accepted quality for insured patients

Appendix B: Sample Logic Model Matrix

		providers. Licensure issues with retired physicians from out of state will be resolved satisfactorily.			
Measures of Success		Number of recruitment contacts made with physicians. Resolution of liability issues. Agreement with state re medical licensure.	Number of physicians enrolled as a % of the available pool. Number of retired physicians recruited.	Number of patients participating. Number and volume of service provided at each neighborhood site. Dollar value of indigent care provided by physicians.	Improvement of CQI benchmarks over time. Comparison of CQI benchmarks with those of insured populations.
Component 2: Development of program data capability to track eligibility, enrollment in the program and referrals.					
Descriptions	I/S staff hired by program. Consultation with hospital I/S staff. Funding from HRSA grant. In-kind and cash funding from community partners	Conduct assessment of existing data resources. Identify and define data elements and functional capacity. Review existing data systems in	Shared database with basic information accessible by participating providers. Shared policies and procedures. Usable reports for client and program	Streamlined enrollment process. Improved access to services. Tracking of referrals across multiple providers.	Enrolled members receiving appropriate services.

Appendix B: Sample Logic Model Matrix

	partners	adjacent counties for appropriateness and adaptability. Research and select vendors for hardware and software.	program management.		
Assumptions	Funding will be available to maintain and upgrade system. Buy-in by community partners	System will be user-friendly. Legal barriers can be addressed regarding information sharing.	Barriers to system use and technology will be addressed. Physicians will use system. Sufficient training in system use and reporting will be available.	Streamlined enrollment and tracking will result in lower costs and improved efficiency.	Streamlined enrollment and tracking will ultimately result in better health outcomes.
Measures of Success	Identification of funding sources	Assessment of data resources. Documentation of system requirements.	All enrollments entered into system. Physicians using system for patient tracking.	Client satisfaction surveys re ease of accessing healthcare, give information once. Cost savings from increased efficiency.	CQI benchmarking process

Appendix B: Sample Logic Model Matrix